Dr. Julie Durnan and Dr. Nina Lange, Naturopathic Physicians
2468 Haywood Avenue, West Vancouver, BC V7V 1Y1
Tel: 604.922.4074 Fax: 604.922.4075
Web: *www.pacificanaturopathic.com* Em: *info@pacificanaturopathic.com*

Confidential Pediatric/Adolescent Case History

Child's Name: ____ **Date:** ________________
Address: ___________________________________ **City:** __________________________
Postal Code:_______________ **Date of birth** ____/____/______ **Age** _____ **Sex: M / F**
(m) (d) (yr)
PHN: (Care Card Number) ____
Parent(s) Contact:
Name: ____
Home #: _________________ **Work #:** __________________ **Cell #:** _________________
Name: ____
Home #: _________________ **Work #:** __________________ **Cell #:** _________________
How did you hear about us?____
Email Address:
____

In your opinion, what are you child's main health concerns, in order of importance:

1. ________________________________ 4. ____________________________________
2. ________________________________ 5. ____________________________________
3. ________________________________ 6. ____________________________________

Please list your child's medications:

	NOW	PAST
Aspirin	_____	_____
Tylenol	_____	_____
Antibiotics	_____	_____
Other______	_____	_____

Supplements:

	NOW	PAST
Vitamins	_____	_____
Minerals	_____	_____
Fluoride	_____	_____
Other	_____	_____

Childhood illnesses:
__ chicken pox
__ red measles
__ mumps
__ rubella
__ scarlet fever
__ rheumatic fever
__ strep throat
__ pneumonia
__ mononucleosis
__ ear infection(s)
__ tonsillitis
__ other________________

Immunizations: List types, when given, and any reactions:
____
____
____

Prenatal/birth/neonatal history:
Birth weight____________ ___ premature ___ late ___ full term

Mother's health during pregnancy:

__ age	__ bleeding	__ extreme nausea
__ illness	__ toxemia	__ trauma / injury
__ stress	__ x-rays	__ high blood pressure
__ diabetes	__ medications	__ cigarettes
__ alcohol	__ drugs	__ other________________________________

Place of birth____

Infant feeding:

__ breast fed: if yes, how long?____________

__ formula fed: how long and types of formula?____

Age solids began:__________ What foods?____

Food allergy/intolerance(s)____

Favourite foods:____

Sample daily diet: choose your child's typical day and include liquids

____

____

____

____

____

____

Hospitalizations/surgeries/accidents/serious injuries and illnesses: (describe each incident and give dates)

____

____

____

____

Family History

Identify all family members who have or have had any of the following:

___	________________	alcoholism	___	________________	allergies
___	________________	anemia	___	________________	arthritis
___	________________	asthma	___	________________	diabetes
___	________________	eczema	___	________________	epilepsy
___	________________	heart disease	___	________________	hearing loss
___	________________	hypoglycemia	___	________________	mental illness
___	________________	obesity	___	________________	stroke
___	________________	thyroid disorder	___	________________	other(s)__________________

____

____

Patient's Health History

Now	Past	Never		Now	Past	Never	
____	____	_____	allergies	____	____	_____	fatigue
____	____	_____	anemia	____	____	_____	frequent infections
____	____	_____	asthma	____	____	_____	headaches
____	____	_____	bedwetting	____	____	_____	heart murmur
____	____	_____	birth defects	____	____	_____	high fever
____	____	_____	colic	____	____	_____	hyperactivity
____	____	_____	cough/wheeze	____	____	_____	insomnia
____	____	_____	croup	____	____	_____	jaundice
____	____	_____	depression	____	____	_____	learning problem
____	____	_____	diarrhea	____	____	_____	moodiness
____	____	_____	dry skin	____	____	_____	stuffy nose
____	____	_____	earache(s)	____	____	_____	thrush
____	____	_____	eczema/rash	____	____	_____	vomiting spells

others: please list:____

____